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Chair

Mr. Ben Lobb

Standing Committee on Health

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● (1535)

[*Translation*]

The Clerk of the Committee (Mr. Marc-Olivier Girard): Good afternoon, everyone.

As you know, the elected chair, Ms. Smith, resigned today, which means the position of chair of the committee has become vacant. So it will come as no surprise to you that your first task today will be to elect a new chair of the Standing Committee on Health.

[*English*]

As a reminder, pursuant to the Standing Orders, the chair must be a member of the government party.

I'm now ready to receive motions for the chair position.

Ms. Eve Adams (Mississauga—Brampton South, CPC): If I might, sir, I'd like to nominate Mr. Ben Lobb.

The Clerk: Are there any other nominations?

[*Translation*]

Is it your pleasure to adopt the motion?

Some hon. members: Agreed.

(Motion agreed to)

The Clerk: I declare the motion carried and Mr. Ben Lobb duly elected chair of the Standing Committee on Health. I invite him to come and take the chair.

[*English*]

The Chair (Mr. Ben Lobb (Huron—Bruce, CPC)): Ms. Davies.

Ms. Libby Davies (Vancouver East, NDP): First of all, congratulations on becoming chair.

I'd like to move a motion that we, as a committee, send a letter of thanks to Ms. Joy Smith. I know she has served on this committee for a long time, also as the chair. It would be nice to send her a letter thanking her for her years of service and interest in this committee.

The Chair: Ms. Fry.

Hon. Hedy Fry (Vancouver Centre, Lib.): I wanted to congratulate you on becoming chair.

I also wanted to concur with and second Ms. Davies' motion with regard to Joy Smith, who has had many years of service with this committee. If we could send that to her in a letter or in some other way, it would be perfect.

The Chair: Thank you, Ms. Fry.

The clerk and I will put together a letter. We'll send it around for review by the committee, so they think it's appropriate, and then we'll forward it to Ms. Smith.

Good afternoon, ladies and gentlemen.

We have a full slate here today. We have four different groups that are going to be presenting. As you know—I'm sure you've been briefed—you each have 10 minutes to present. We'll carry right through. Once we get close to 10 minutes, I'll put my hand up so that you will know you're getting close. But I'm sure your notes are put together in such a way that you're going to be right on the 10 minutes.

We'll start with the Department of Justice. We have Mr. Saint-Denis and Ms. Goldstone. Whoever is presenting can start.

Ms. Jennifer Goldstone (Acting Head, National Anti-Drug Strategy, Department of Justice): Since the Department of Justice Canada heads the national anti-drug strategy, it's a pleasure for me, as the acting head, to be here today to say a few words about the strategy.

The strategy aims to contribute to safer and healthier communities through coordinated efforts to prevent use, treat dependency, and reduce production and distribution of illicit drugs. The strategy is a collaborative effort involving 12 federal partner departments and agencies, with $515.9 million allocated for this current five-year cycle of 2012-2017.

[*Translation*]

The strategy includes 22 programs that are delivered through three action, prevention and treatment plans, managed by Health Canada. Public Safety Canada is responsible for enforcing the act.

[*English*]

The strategy focuses on illicit drugs, as set out in the Controlled Drugs and Substances Act. Since the launch of the strategy in 2007, misuse of prescription drugs has emerged as a significant public health and public safety issue, resulting in addictions, overdoses, fatalities, and crime.

Prescription drugs are often obtained from the medicine cabinet of a friend or a family member. They're also being diverted and distributed through many of the same illegal channels that are used by illicit crime groups, that is, organized crime. Prescription drugs are obtained through armed robberies and break-ins of pharmacies, fraudulent use of the health care system, such as double-doctoring and forgeries, sales by individuals taking advantage of the lucrative street markets, and illegal Internet sales.

While some federal departments address misuse of prescription drugs as part of their mandates, it requires a policy authority expansion to use some of the national anti-drug strategy money towards addressing this important issue.

In the 2013 Speech from the Throne, the Government of Canada committed to expanding the NADS policy authority—I say NADS for national anti-drug strategy—to address prescription drug abuse. There's also been strong consensus among stakeholders, including first nations groups, medical and research communities, and enforcement and pharmaceutical communities, that collaborative action is needed.

Paul.

Mr. Paul Saint-Denis (Senior Counsel, Criminal Law Policy Section, Department of Justice): Thank you, Jennifer.

I have no presentation to make per se. If you have questions in the area of criminal law or in the area of offences and penalties with respect to the Controlled Drugs and Substances Act, I'll endeavour to answer those questions.

The Chair: Okay, so that's the conclusion of your presentation, then. Thank you very much for your brevity. That allows for more questions at the end.

Next up is the Department of Public Safety and Emergency Preparedness. Forgive me if my pronunciation is incorrect, Mr. Bhupsingh; and we have Ms. Goguen as well.

Please, sir, go ahead.

[*Translation*]

Mr. Trevor Bhupsingh (Director General, Law Enforcement and Border Strategies Directorate, Department of Public Safety and Emergency Preparedness): I would like to thank the chair and committee members for inviting me to speak to you on prescription drug abuse and its impact on public safety.

My department is responsible for the Enforcement Action Plan, which is a part of Canada's National Anti-Drug Strategy. This responsibility means that we have to work in close cooperation with various partners, among them the Royal Canadian Mounted Police, the Department of Justice, and Health Canada, so as to ensure that government interventions in the fight against drugs are coordinated, in particular as regards marijuana grow-ops and clandestine laboratories that produce synthetic drugs such as ecstasy.

● (1540)

[*English*]

Within this role, Public Safety has sought to continuously address new and emerging issues impacting public safety with respect to drugs. In recent years, there is increasing evidence to suggest that the illicit use of prescription drugs is a major public safety concern in Canada.

From an enforcement perspective, the criminality associated with prescription drug misuse includes fraudulent use of the health care system, pharmacy robberies, drug-impaired driving, and more traditional drug-trafficking activities, both by criminal organizations and individuals looking to profit from a lucrative street market. Meanwhile, these licit drugs challenge traditional supply reduction approaches.

Public Safety has worked closely with the Canadian Association of Chiefs of Police drug abuse committee over the years to raise awareness about this issue impacting our communities. As many of you know, the illicit use and/or misuse of pharmaceuticals, in particular, narcotic opioids, has become an issue of increasing concern with the impacts on public safety and the community well-being. In fact, trends indicate rising rates of recreational misuse of prescription drugs by our youth, the majority of whom obtain these drugs from family medicine cabinets or from friends.

This is why, in June 2011, Public Safety hosted a national workshop on the illicit use of pharmaceuticals, in Vancouver, attended by over 100 participants representing federal, provincial, and municipal law enforcement, as well as health officials, including physicians and pharmacists. The goal was to facilitate multi-sectoral discussion and to increase the overall understanding of the issue of pharmaceutical misuse from a public safety perspective.

Following the workshop, Public Safety invested in a pilot project in the Niagara region to hold a prescription drug drop-off day in May 2012. The goal of the event was to safely dispose of unused or unfinished medications in order to limit the possible misuse of these medications. This initiative was very successful. In just one day, 4,000 kilograms of medications were collected, including 835 oxycodone pills, over 3,400 Percocet and Oxycocet pills, over 5,000 codeine pills, and 23 fentanyl patches.

Building on the success of this particular pilot, Public Safety supported the CACP in implementing their resolution to hold a national prescription drug drop-off day and to mobilize law enforcement efforts. Public Safety held a workshop and developed a handbook—I think copies of the handbook were given to members, Mr. Chair—targeting a new law enforcement to support them in their first national annual drop-off day held in May 2013, so earlier this year. This handbook, which has been shared internationally, highlights current prescription drug return initiatives in Canada and is available on both the PS website and the national anti-drug strategy website.

In line with this national day, Public Safety, in collaboration with Health Canada, put forth a resolution at the UN Commission on Narcotic Drugs, on behalf of Canada. This resolution was adopted on March 15, 2013, by the commission. It called on member states to promote initiatives for the safe, secure, and appropriate return for disposal of prescription drugs, in particular, those containing narcotic drugs and psychotropic substances under international control.

Public Safety has also worked closely with the Canadian Centre on Substance Abuse, the CCSA, in the development of the national framework on prescription drug misuse. Specifically, in collaboration with the Canadian Association of Chiefs of Police drug abuse committee, they led the development of the enforcement pillar for the CCSA's strategy, *First Do No Harm: Responding to Canada's Prescription Drug Crisis*. We are currently in the process of developing an implementation plan of this pillar.

[*Translation*]

I thank you for having given me this opportunity to give you an overview of the role my department plays in the National Anti-Drug Strategy, and for the work you have done up till now to manage the issue of prescription drug abuse.

I would be pleased to reply to your questions. Thank you.

[*English*]

The Chair: Thank you very much, Mr. Bhupsingh.

Next up we have the Royal Canadian Mounted Police.

Mr. Cormier, I believe you are going to provide the speech today. Go ahead.

Inspector Jean Cormier (Director, Federal Coordination Centres, Royal Canadian Mounted Police): Good afternoon, Mr. Chair, and first of all congratulations on your election to the position of chair.

Honourable members of the committee, thank you for inviting the RCMP to participate in these proceedings. I am happy to be here today with my colleague and partners.

I am Inspector Jean Cormier, and I currently hold the position of director of the federal coordination centres within the RCMP's federal policing program at national headquarters. The federal coordination centres provide subject-matter expertise to many of the enforcement initiatives supported by federal statutes.

● (1545)

[*Translation*]

Today I am accompanied by Corporal Luc Chicoine, who is one of the RCMP's Drug Initiatives National Coordinator at RCMP National Headquarters.

Thank you for the opportunity to say a few words about the RCMP's engagement with this important issue, as well as our relationship with the different partners from the Canadian government involved in addressing the issue of prescription drug abuse.

[*English*]

Prescription drug abuse is a serious problem affecting citizens of our country. The misuse and abuse of prescription drugs has always been present, but recently it has become increasingly prevalent and therefore requires the attention of all of us. Non-medical use of prescription drugs is the third-most prevalent form of drug abuse among Ontario students. Information from Health Canada estimates that it is at 16.7% just behind cannabis at 22% and alcohol at 55%.

[*Translation*]

The misuse and abuse of prescription drugs has devastating impacts on the citizens of Canada. It is important to note that this issue is felt across all age groups, races, social classes, incomes, ethnic backgrounds and genders. The misuse and abuse of prescription drugs directly affects the Canadian population as a whole, our businesses, communities, and our international reputation.

One of the dangers posed by prescription drug abuse is the false sense of safety users have, as it is prescribed by doctors, manufactured in regulated facilities and provided by pharmacists. However, when these prescription drugs are misused, they come with the same devastating impact as other illicit drugs.

[*English*]

It is important for law enforcement to work collaboratively with domestic and international partners to identify, prevent, and detect the diversion and trafficking of prescription drugs by pursuing those who engage in such activity. The RCMP and other domestic police services are often the first responders to incidents of prescription drug abuse. Education and training of officers is an important step in properly addressing the situation.

[*Translation*]

We believe that information-sharing between different private and public partners is crucial in addressing this problem.

The National Anti-Drug Strategy promotes a three-pillar approach —prevention, treatment and enforcement. The RCMP is an active participant within the National Anti-Drug Strategy so as to deal with the problems related to prescription drug abuse.

[*English*]

The investigation of abuse or diversion of prescription drugs is complex and challenging. In spite of this, the RCMP in concert with its partners is focused on two of the national anti-drug strategy pillars —prevention and treatment.

All RCMP officers are technically responsible for investigating illicit drug-related activities. We do, however, have officers such as Corporal Chicoine here who have special training in drug investigation who are also considered subject-matter experts. These resources also have a responsibility to investigate illicit activities related to prescription drugs. There are some of these trained resources situated in all provinces and territories across Canada.

[*Translation*]

Although international cooperation has come a long way in establishing standards to prevent and detect prescription drug abuse, such as the elimination or further restriction of certain prescription drugs, continued effort and a sustained focus must be maintained.

The RCMP believes that everyone has ownership and a role to play in the prevention of prescription drug abuse.

[*English*]

It is our belief that focusing on prevention by raising the level of awareness within our communities, including our health care practitioners, of the misuse and abuse of prescription drugs will assist in conducting successful enforcement action that will suppress criminal activities. The RCMP is committed to efforts to detect and deter prescription drug abuse, which has a negative impact on Canada and the well-being of Canadians.

I thank you and look forward to answering your questions.

● (1550)

The Chair: Thank you very much, Mr. Cormier.

Our final speaker of the afternoon is Correctional Service of Canada Commissioner Don Head.

Go ahead, sir.

Mr. Don Head (Commissioner, Correctional Service of Canada): Thank you, Mr. Chair.

Good afternoon, Mr. Chair, and members of the committee.

I'm pleased to have the opportunity to appear before you today to provide input into this committee's study on the government's role in addressing prescription drug abuse.

Mr. Chair, as Commissioner of the Correctional Service of Canada, or CSC, I oversee the operations of Canada's 53 federal penitentiaries, 16 community correctional centres, and 92 parole offices and sub-offices. On a typical day during the most recent fiscal year, CSC was responsible for 22,762 offenders, of whom 15,056 were incarcerated.

It will likely come as no surprise to this committee that substance abuse within the offender population is an ongoing problem. Our data indicates that approximately 80% of offenders arrive at federal penitentiaries with a history of substance abuse problems, many of whom have had issues with more than one substance. Equally concerning, it has been determined that drugs or alcohol were a factor in the crimes for which roughly half of the offender population were convicted. This statistic has remained constant over many years.

Within federal penitentiaries, my front-line staff have the responsibility of addressing the serious threat that drugs pose to the safety and security of institutions on a daily basis. Without question, reducing the supply of illicit drugs has been a priority of my organization. Through measures such as drug detector dogs and enhanced security intelligence, CSC has focused on preventing drugs from entering our institutions, and in turn created an environment that is both safer for our staff and inmates as well as more conducive to the effective rehabilitation of offenders.

In addition to initiatives that seek to reduce the supply of drugs, CSC has been equally determined to reduce demand for drugs. To this end, CSC provides drug treatment and substance abuse programs that assist offenders in their rehabilitation and in addressing the criminogenic risk of substance abuse. Indeed, CSC is widely considered to be an international leader with respect to its substance abuse programming and treatment.

Mr. Chair, CSC is certainly capable of providing insight into both illicit drug interdiction and treatment. However, where CSC may be most helpful to this committee is on the subject of actually administering prescription drug delivery in a very challenging institutional environment.

As this committee may be aware, CSC is mandated to provide essential health care services to all federal inmates. As part of this mandate, CSC must ensure that offenders are afforded reasonable access to required prescription medications. As this committee can no doubt imagine, managing the distribution and administration of prescription drugs to a client base of federal inmates presents a unique challenge due to the high risk that offenders pose in terms of abusing these medications.

Given this risk, CSC has created a system that limits the potential for these substances to be abused but maintains a high level of medical care. The most notable element of our policy framework is the Correctional Service of Canada's national formulary. This document, by which all federal penitentiaries must abide, provides a tool to physicians and pharmacists to encourage the selection of optimal and cost-effective medications. The formulary, which is produced by health care professionals and updated twice each year, provides a list of medications that CSC is prepared to provide to federal offenders when medically required.

By extension, any medications that represent a potential risk for an institutional setting are excluded from the formulary, and if that is not possible for medical reasons, restrictions are placed on how the drug is prescribed and administered.

Of particular relevance, the formulary also provides information for specific drugs in terms of available alternatives, how they are to be safely distributed to offenders, in what dosage and in what supply, for what duration, and under what circumstances.

I believe that the means by which CSC safely delivers prescription drugs to federal inmates is of direct relevance to this committee's study. Although consideration for time prevents me from providing specific details regarding these policies in my opening remarks, I'd be pleased to answer any questions this committee may have on this subject.

Thank you, again, Mr. Chair, for the opportunity to appear before you today.

● (1555)

The Chair: Thank you, Mr. Head.

We'll start our first round of questioning. We'll start off with the NDP.

Ms. Davies, go ahead.

Ms. Libby Davies: Thank you very much.

First of all, thank you to the witnesses for being here today. I'm interested to hear your presentations and what each of your departments is doing.

Mr. Bhupsingh, you mentioned in your brief that there's increasing evidence to suggest that illicit use of prescription drugs is a major public safety concern. Could you table any documents you have that actually give us that evidence? I don't know whether you're talking about polls or reports that have been done, or surveys. I'm not sure what you're referring to, but if you could table that with the committee, it would be very helpful.

The other thing that strikes me in hearing the presentations today is when we hear about what's taking place in terms of the drop-off day. I have no problem with the idea that there's a national drop-off day, and that we're involved in organizing it, and that there was a resolution at the UN, but it seems to me that to focus on a policy of appropriate return is sort of after the fact. I didn't hear any of you speak about what we do in a systematic way to prevent abuse in the first place.

In B.C., we have systems within our pharmacare program and through pharmacies where checks and balances are in place to ensure that people aren't shopping around for prescription drugs. It's hard to know whether any of your departments, or Health Canada for that matter, are involved in trying to promote something like that on a national level.

My question is, why are we focusing so much on after the problem has already happened, as opposed to putting systems in place?

Mr. Head, you said you do have systems in place. Maybe you can address that in terms of what we can learn from that, but I am concerned that we don't seem to have any systematic way of dealing with this issue. It seems to me that looking at it solely from a law enforcement argument is missing the boat. We need to look at how the system itself, in terms of the dispensaries, ensures that we're minimizing, as much as possible, any abuse from taking place.

Could any of you address that?

Mr. Trevor Bhupsingh: Mr. Chair, thank you.

First of all, in my reference to the increasing trends we're seeing in pharmaceuticals, prescription drugs, a lot of that is just what we see in terms of investigations. In new cases coming before public prosecutions, etc., we see an increase. Those are the trends I'm talking about.

Mr. Chair, a number of studies referenced in earlier submissions, by Health Canada, by other members, are clear. We see a growing trend in this. What I'm suggesting is that we don't see anything different, at least from a public safety perspective, to counter that trend. With respect to systemic abuse, I would say that I'm from the law enforcement community, but I know Health Canada—and Health Canada was here last week—was talking about a number of systems they're attempting to put into place.

I am not the best placed to comment on an upfront, systematic approach to this. What I can speak to is that in addressing some of the law enforcement supply-reduction concerns, we're moving forward, and we think that, ultimately, take-back days and those types of initiatives can have an effect. I know that's not a systematic system such as you're talking about, but in terms of addressing some of the law enforcement concerns, we think that's an appropriate way to intercept some of the supply.

● (1600)

Ms. Libby Davies: From a public safety point of view, wouldn't your first approach be to have a much better regulatory system in place? Whether they're deemed legal or illegal, we are dealing with substances that can be misused, that can be powerful, that can have a very negative impact if they're not used properly.

I haven't heard any of you speak of this. It seems to me we need to have a regulatory system up and running so that we do have those checks and balances.

Mr. Trevor Bhupsingh: My only comment would be that there's a lot of collaboration. There are jurisdictional issues. My understanding is that the provinces have a large role in regulating controlled substances. I agree that we have a role. To the extent that we have a role putting in place systems, I think we're looking at and attempting to do that.

Again, from a health perspective and just in terms of responsibility, those would probably be good questions for colleagues at Health Canada.

The Chair: Mr. Saint-Denis, did you want to add something?

Mr. Paul Saint-Denis: I have a couple of observations, Mr. Chairman.

One is that, as I recall, the health representatives when they were here pointed out that Canada is the second-highest consuming nation of prescription drugs. That means that the number of drugs that are circulating is high indeed. And they're circulating through legitimate means; these are drugs that are being prescribed. So when we talk about a systemic problem, there may be an issue there with respect to the proper prescribing of drugs.

A lot of the drugs that are prescribed end up sometimes being stolen, sometimes being misused. There's theft of drugs from pharmacies. I don't think that a systemic regulatory approach would solve or correct or prevent thefts from pharmacies, thefts from homes, thefts from elderly residences where drugs are stolen.

Ms. Libby Davies: I don't disagree with that, but for sure if there were some kind of system in place that prevented people from shopping around and getting double or triple prescriptions, if there were a check system in place, surely that would be a vast improvement. Would you agree that needs to be done?

If it's done in one province or maybe a couple of provinces, great, but there are huge gaps across the country.

The Chair: We're over time, so please give just a real quick response there, if you have one.

Mr. Paul Saint-Denis: In terms of a national approach—as you're aware, we do have the offence of what's essentially called "double-doctoring"; it is not that—the offence is seeking to obtain or seeking a narcotic. That applies nationally. As Ms. Davies has pointed out, there are certain provinces that have a systemic computerized mechanism for dealing with prescriptions and keeping track. Perhaps it's something that could be done across the country, but these are issues that are regulated by the provinces, so it really comes down to provincial intervention in that area.

The Chair: Thank you, Mr. Saint-Denis.

Next up for a seven-minute round is Mr. Hawn. Thank you, sir.

Hon. Laurie Hawn (Edmonton Centre, CPC): Thank you very much, Mr. Chair.

And thank you to our witnesses for being here.

I have a number of questions, so I'd appreciate reasonably concise answers, if you could. I'd like to start with Public Safety.

There's some talk about grassroots, getting into community groups and so on to work with them. I think it would be fairly common sense to attack it at the lowest possible level—community groups and so on dealing with youth and keeping the youth off drugs.

Can you speak to the level of coordination with community groups? Do you have any examples of that? Does big pharma have a role to play in that on the education side?

Mr. Trevor Bhupsingh: One of the things we're looking at.... I agree, Mr. Chair, that there are probably a number of ways we can go at it with respect to, I would say, almost awareness, at a number of different levels.

The problem we're seeing on the law enforcement side is that this ranges from some nexus to organized crime in some ways, down to just individuals. In dealing with the individual aspects of it, I think you're right, there's probably an opportunity for us to start some awareness campaigns that are grassroots, in local communities. I think that on a go-forward basis that is something we'll look at.

With respect to pharma, there probably is a role. What could be done? Ultimately there are a number of things, in terms of discussion with them, control mechanisms, etc. Again, that's part of the solution.

But the focus for us is really about awareness, number one, that this is a growing issue, and then number two, attacking this probably at a number of different levels, including the grassroots and individuals and you guys.

● (1605)

Hon. Laurie Hawn: This is a subjective question that will probably generate a subjective answer, but where do we start with young people to talk about abuse of prescription drugs and abuse of illegal drugs or illegal substances such as marijuana? Do we start at grade 6, grade 5, grade 4? Where do we start?

Ms. Taunya Goguen (Manager, Serious and Organized Crime, Department of Public Safety and Emergency Preparedness): I don't have a great answer for you other than to say that this is within Health Canada's domain and it's really their area of expertise.

I know that the RCMP also has some programs targeting youth, so they may want to add a word.

Hon. Laurie Hawn: Sure. Go ahead.

Insp Jean Cormier: I can add to that, for sure.

We have a number of different awareness programs. One of them is the aboriginal shield program, which targets in principle the aboriginal community and certainly the youth starting at school age.

We also have the drug abuse resistance program, which is well known as DARE. That also targets kids of school age, but more in grades 7 and 8, before they go to high school, where they are more likely to be exposed to, or get offered, different types of drugs. Again, it's about awareness and prevention.

We also have DEC, the drug endangered children program, an early intervention initiative that seeks to stop the cycle of child abuse caused by the exposure to drug activities. The program involves a resource guide, which has been translated into French, and training program service delivery personnel have access to that.

Hon. Laurie Hawn: Thank you.

Through you, Mr. Chair, to Commissioner Head, you talked in your remarks about CSC being an international leader with respect to substance abuse programming and treatment.

Can you expand on that a little bit, the programming and more specifically the treatment for drug abuse within the system?

Mr. Don Head: Most definitely. Over the last 20 years, we've developed a series of programs, based on research, that target various issues, substance abuse being one of the bigger issues that we deal with. Through that research and the work of our staff, we've developed various substance abuse programs that are delivered to offenders. These are moderate-intensity programs and high-intensity programs, even to the point where now the programs have also been tailored to address the specific needs of aboriginal offenders and also some of the unique needs of women.

Many countries around the world have adopted our programming framework and have put it in place in their jurisdictions.

Hon. Laurie Hawn: Can you describe a high-intensity program?

Mr. Don Head: A high-intensity program would run anywhere from 12 to 18 weeks and require engagement four to five days a week, for three to four hours. Then there's ongoing follow-up with front-line staff, with the parole officers who look after the cases and any other individuals who would be interacting with the offender.

Hon. Laurie Hawn: I'm trying to drill down here a little bit. Can you be a little more specific on exactly what goes on? Is it abstinence from drugs? Is it supplying drugs and tapering off? Or how do you do that?

Mr. Don Head: It's based on a social-psychological model in terms of presenting situations to individuals and having them look at alternatives other than going to drugs. It's looking at how to make better choices, how to make smart choices that do not involve drugs, alcohol, or any other intoxicant.

A cognitive-behavioural model is the model that we've been using.

Hon. Laurie Hawn: Does that involve supplying them drugs in the process?

Mr. Don Head: Our belief is that we need to have drug-free prisons, and we'll continue to operate in that manner. That's our enforcement piece. Our treatment piece is along the lines of the programs that I'm talking about.

Hon. Laurie Hawn: Again, this may be a bit out of your lane, but if that works within the correctional system, where obviously you have, pardon the expression, a captive audience, would you see the same application for people outside of the prison system in terms of treating drug abuse?

● (1610)

Mr. Don Head: I think there is a good framework there to be followed. We have worked with some community-based organizations, because one thing we're really interested in is that any gains the offenders make while they're incarcerated will get carried over into the community. We will deliver a maintenance program for offenders under the supervision of the community, but we also will work with other agencies so that they can support those offenders beyond the warrant expiry date.

Hon. Laurie Hawn: Thank you.

That's it, Mr. Chair.

The Chair: Thank you, Mr. Hawn.

Next up we have Ms. Fry.

Hon. Hedy Fry: Thank you very much.

Those were very interesting presentations by everyone.

I know that what you are specifically dealing with as part of the team is the supply side, but from my knowledge as a physician and my understanding of these issues over the years, you can't only deal with supply side at any one point in time. You have to look at why the demand; the demand side is something you have to look at.

I would like to reiterate Mr. Hawn's request for short, crisp answers. I'll try to ask short, crisp questions.

Mr. Head, you said that 80% of offenders who came in were addicted in some way, or were taking medication of some kind, either prescription or illicit. I also note you said that after 20 years of doing this, this statistic has remained constant. Do you look at evidence-based...? I mean, if some statistic remains constant over 20 years, is there an opportunity to look at whether or not this is the right procedure?

Mr. Don Head: Yes, we do use evidence. The 80% figure is not the same group of people who move through the system. As new admissions come into the federal system, 80% of them have had some kind of substance abuse problem in their life.

Hon. Hedy Fry: Are these people sort of a high recidivism rate among substance abusers in prison? Aren't they the same people going out and coming back in later on?

Mr. Don Head: No. In any given year, about 75% of the offenders coming into the system are first-time admissions to the federal system.

Hon. Hedy Fry: And how often do they come back?

Mr. Don Head: If we're looking at two years beyond warrant expiry, approximately 10% of them come back. After five years, it's about 20%.

Hon. Hedy Fry: You work with a community, you say. Looking at your statistical data, what is the community showing with regard to those who go out and never come back?

Mr. Don Head: We find that the individuals who take the substance abuse programs that we're offering, both the institutional ones and the community maintenance programs...we see those individuals up to—just that program alone—up to 63% of them do not commit a new offence or a violent offence.

Hon. Hedy Fry: You say there's a maintenance program. Does that mean things like substitution programs in the community using methadone and things like that?

Mr. Don Head: We use an opioid substitution therapy in the institution and if somebody has started it there, we'll look to link them up in the community as well. We find that individuals who go through the methadone program, who have been addicted to heroin, have a better chance of success than if they do not go through that program.

Hon. Hedy Fry: I agree with you on that, but there is now a very large body of work telling us that there is a small percentage of high-risk individuals who do not respond to any of the current substitution programs such as methadone or suboxone. The question, then, is what about a program that works for them? If you believe, and you said earlier that you agree with evidence-based results.... If the evidence shows that some of this very tiny group of people needs to take the pharmaceutical drug diacetylmorphine, would you not consider that to be a substitution treatment for that tiny group of people?

Mr. Don Head: That would be something that we would look at. We would go through the normal processes for any substitution drug to be added to the formulary. We would look at the issues of efficacy and effectiveness as well as cost, but we'd also look at that. One of the overlay issues is the potential impact of that kind of drug being in an institutional setting. It's one of the factors we have to always weigh.

Hon. Hedy Fry: Yes, I think that's important because now there's a huge set of studies that are showing that in fact for that tiny group, if they don't get diacetylmorphine or hydromorphone, which is Dilaudid, they will go onto street drugs again. So that's one way of stopping them getting back into that street drug system. I'm glad you think that evidence should work in some of these things.

I wanted to talk about the idea—and I don't know who should answer. Mr. Chair, you might want to direct that to whoever should answer it—you talked about the First Do No Harm program. Does that mean that you think that harm reduction is an important piece, if First Do No Harm is the obvious medical ethic? Who wants to answer that?

I noticed that no one had harm reduction as part of their comprehensive package of looking at substance abuse and at looking at decreasing the amount. Who wants to...?

Mr. Chair, who wants to take the First Do No Harm and tell me why there is no harm reduction in your programs?

● (1615)

The Chair: Who would like to take that question on? Public Safety? RCMP? Would anybody like to tackle that question?

Ms. Jennifer Goldstone: I can answer part of it and my colleagues can chip in.

There were representatives from the federal government involved in this report called First Do No Harm that was led by the Canadian Centre on Substance Abuse. I think you'll be hearing from Michel Perron later this week, and Public Safety led the enforcement action plan. Lots of good ideas and lots of good recommendations came out of this report including one which was to expand the policy authority of the National Anti-Drug Strategy to include prescription drug abuse. But it has not been related to discussions about harm reduction.

Hon. Hedy Fry: I know the Canadian Centre on Substance Abuse has harm reduction as one of their pillars. So I just wondered why are we cherry picking some things and not others, especially when internationally it has been shown that harm reduction is of use. In Australia, in Europe, it is now completed accepted as a piece of that, because when you reduce harm and the person knows they're not going to die, their tendency to want to be treated becomes greater.

How much time do I have, Mr. Chair? A quick minute.

Ms. Davies talked about coordinating. I remember, in 2002, the report from the committee on this issue suggested that everyone integrate the work they do. Integrating the work that you do means working with the provinces, etc.

I know that in British Columbia there's a triplicate program for opiates. It means that when the doctor writes a prescription, there are three pieces to it. The doctor keeps one, the pharmacist gets one, and the colleges get one which they share with the police, and therefore you stop. It's been very effective in stopping double-doctoring.

Why wouldn't you, working with the provinces, think this is a good idea to promote as a national strategy? It's not just provinces. You're working with them. You all said that—that this integrated approach is working. So why wouldn't that happen, especially with people the federal government is responsible for, like Inuit, first nations, and the armed forces?

Mr. Trevor Bhupsingh: Those are all good ideas. I don't think anybody on this panel can really speak to them with any authority, though.

Again, Mr. Chair, I think this is largely in the neighbourhood of Health Canada,

Hon. Hedy Fry: No, because this works for the police in the provinces that I talked about. They're part of that program.

The question is, why can't we do that nationally, given that you are working with provinces? Everybody is working together without any gaps in the system. That's all I wanted to ask. Do you not see the benefit of doing that kind of thing and getting results?

The Chair: Thank you for the questions. We're a little over time here.

Hon. Hedy Fry: Sorry.

The Chair: If any of our guests have a take-away thought and would like to get back to the clerk of the committee at a later time, you're quite welcome to do so.

Thank you.

Next up, for a round of seven minutes, we have Mr. Wilks.

Go ahead, sir.

Mr. David Wilks (Kootenay—Columbia, CPC): Thank you, Mr. Chair.

I thank the witnesses for being here today. Most of you are from the enforcement side, so it becomes somewhat tricky, shall we say, from time to time, when you're talking about treatment and prevention. Most of the dialogue that you people are dealing with is on the enforcement side.

Mr. Cormier, sir, I'll lean my first question to the RCMP. I'm a retired member, so I'll respect the rank. Back in 2009—I don't know if the RCMP stopped collecting—they used to publish an annual drug situation report.

Could you tell me if that still goes on? If it does, where can it be found, or is it internal?

Insp Jean Cormier: My expert here advises me that it's no longer being published. Those types of reports, as you acknowledged, were being published in 2009. Things have changed since then.

Mr. David Wilks: Okay.

Is there an anticipation...? It seems to me that it would be a valued report for all people concerned to know the drug statistics from the RCMP across Canada.

Insp Jean Cormier: Right.

The statistics in relation to prescription drugs, I believe, would be maintained by Health Canada. We do have statistics on seizures certainly. We would have access to that already.

Mr. David Wilks: Okay.

Certainly, from my perspective anyway, there will always be a portion of society who is not concerned about treatment and prevention. Their job is to actually lure people into the problem.

This may be directed to the Department of Justice, but is there anything under the CDSA or FDA, or the Criminal Code, for that matter, that may relate to the context of prescription drug misuse or abuse? There's not a lot in there right now, aside from double-doctoring.

● (1620)

Mr. Paul Saint-Denis: I'm not sure exactly what you're trying to look for. There is the offence of double-doctoring in the CDSA. The Criminal Code doesn't really have anything that's relevant to this area. If you're talking about contextual type offences or things of that nature—

Mr. David Wilks: What I'm talking about is someone obtaining 50 T3s—they used to sell for five bucks each—and person X sells T3s to person Y. There's no provision for the selling of T3s.

Is there an opportunity to expand upon that? It seems to be becoming a problem with prescription drugs being sold to another person, but there's no mechanism for the charge.

Mr. Paul Saint-Denis: I'm not sure exactly what a T3 is.

Mr. David Wilks: Tylenol 3.

Mr. Paul Saint-Denis: Okay.

I know that we have the trafficking offence. Trafficking offences apply to pretty well all the scheduled drugs. If this particular drug, for instance, falls under one of these schedules, the trafficking in that drug would get caught, as well as possession for the purpose of trafficking, for instance.

I'm not familiar with that particular drug, so I don't know if it's actually listed in one of these schedules.

Mr. David Wilks: Could I defer to the RCMP on that?

Insp Jean Cormier: If it's a drug that falls under barbiturates or would fall under one of the schedules that Monsieur Saint-Denis is referring to, it certainly would apply under the CDSA. We would investigate the offences under the Controlled Drugs and Substances Act. We would likely charge the individual involved, either for possession for the purpose of trafficking, or trafficking.

Mr. David Wilks: Thank you.

Trevor, you mentioned in your presentation that prescription drugs are prevailing. Are there certain types of prescription drugs that have been documented as more abused than others?

Mr. Trevor Bhupsingh: That's probably best posed to my colleagues at the RCMP on the operations side.

Insp Jean Cormier: I would not have those statistics, I'm sorry.

Mr. David Wilks: Part of the problem seems to be that we've fallen into a grey area with regard to prescription drugs. Back in my day—I hate to date myself, but pre-charter—there wasn't as big a deal about prescription drugs because back then we were more focused on the illicit drugs that were coming in. But we've found a clientele within organized crime that has found a great opportunity to make money on prescription drugs.

One of the things you mentioned, Mr. Head, was how you control how that goes out, what kind of drug a person can get, and why they can get it or why they can't get it in federal facilities. I wonder if you could expand on that a bit, because that seems to be something we could take to the health community to help them as well.

Mr. Don Head: For us, that's guided by what we call our national formulary which, among other things, lists all of the drugs that can be prescribed within the correctional setting.

Mr. David Wilks: Where is that found?

Mr. Don Head: It's in our policy framework. We can actually make a copy of that available to this committee.

Mr. David Wilks: Would you mind, please?

Mr. Don Head: No problem.

Mr. David Wilks: Thank you.

From that, how do you determine who gets what and how much? Please walk me through that process.

Mr. Don Head: First off, we are reliant upon the licensed health care professionals to make their appropriate determinations. Whether that be the physicians, the pharmacists for dispensing purposes, or licensed health care nurses for the actual distribution, we are dependent on them. But in the formulary, based on input that we get through the assistance of Health Canada and their process for approving drugs, and then our own internal pharmacy and therapeutic committee that reviews those drugs that are approved... they look at issues around effectiveness, efficiency, and cost, as well as whether they pose a security problem in the institution.

Once they determine that it will go on the formulary and based on the advice from professionals, they would indicate what dosages could or should be dispensed for any given situation. It's a guide, a framework, that is used and that all of our institutions are expected to follow.

● (1625)

Mr. David Wilks: Thank you very much.

The Chair: Next is Mr. Marston.

Mr. Wayne Marston (Hamilton East—Stoney Creek, NDP): Thank you, Mr. Chair.

Welcome to everybody.

I was going to direct a question to Mr. Bhupsingh, but everybody else has already been pushing him a little bit, so I'll save that one for the end.

To Mr. Cormier, there's been some change of late relative to medicinal marijuana going from the small home producer. It looks like there's a significant change coming. From the standpoint of current enforcement, how often have these places been broken into and their product—that's a strange word—stolen? Is there much of that happening?

Insp Jean Cormier: I don't have the statistics in regard to that, and it may be a little bit off the subject we're discussing here today.

Mr. Wayne Marston: Well, the medicinal side is what made me think in terms of that because we were talking about the abuse of prescriptions and medicinal marijuana should, hopefully, be prescribed—I would presume it to be. What brought that to mind is that during the break week, I spoke to two different schools—grades 4 and 5—and because of a particular leader talking about legalizing marijuana these days, I was quite surprised that the grade 4 and 5 students were asking questions about marijuana. It led me to that particular question.

Going a little further, we have information about a report from Public Safety Canada. Mr. Wilks touched on it earlier, about the misuse of drugs. Would you say that enforcement officials—RCMP, municipal officers as well—are receiving enough training to identify the abuse? If not, where would you see it lacking?

Insp Jean Cormier: I think the officers in general—RCMP, municipal, and provincial police force agencies—are receiving adequate training. But I think it's something that has to be continuous, because you can never receive enough training. It's not because the training they receive is not good, it's simply that there has to be an evergreen program. New officers come online and their training has to continue. New drugs come online and there has to be training in relation to them. So the education of officers has to be a continuous process.

Mr. Wayne Marston: I would anticipate it would have to be just given the turnover in officers alone.

Who would provide that training?

Insp Jean Cormier: It's available through different means. For example, we have the drug investigator's course that's delivered at the Canadian Police College. Some of the municipal and provincial police forces also offer their own training. For example, Corporal Luc Chicoine, who is here today as well, lectures at many of those training courses that are organized by the RCMP or other municipal or provincial police forces.

Mr. Wayne Marston: Would that be the total of the resources that are available for a municipality to develop its own enforcement strategies and what their particular community response might be? Would that be pretty well the total of what's available currently for them?

Insp Jean Cormier: Like I said in my opening remarks, enforcement is everybody's responsibility. Education is everybody's responsibility, so definitely making training available to their officers on a municipal level would certainly be a good start towards prevention.

Mr. Wayne Marston: I spent a lot of time on the United Way board in Hamilton. Substance abuse was a topic that would come up from time to time and that balance a police officer has between where do I make an arrest, look for a conviction, and where do I go to get that person help. I'm sure that's troubling to all officers when they are first starting to get involved with their careers.

Insp Jean Cormier: The training is not only for officers. It's also a community response with health professionals in the community, especially when it comes to prescription drugs. Obviously they have a role to play as well. Social workers would have a role to play. Different partners would have a role to play in that as well.

● (1630)

Mr. Wayne Marston: We in the official opposition have had concerns about whether the resources provided to the police services in particular and other support services are adequate around the country. When you listen to how 80% of the folks who are incarcerated are going there with some kind of a problem, it's pretty clear in our communities we have significant problems for that high a percentage to be in that circumstance.

The Chair: Excuse me, Mr. Marston.

If you have a quick question, please ask it. We're at five minutes already.

Mr. Wayne Marston: I thought it was seven minutes. My apologies.

The Chair: No problem.

Mr. Wayne Marston: I tend to go on, as you will find out when you get to know me better.

It's crucial the supports are there. That's all I'm saying. I'll just wrap with that because you have been so gracious, Chair. This is your first day.

The Chair: Thank you. For that I'll say all the best to the Tiger-Cats this weekend.

Next up, Mr. Dreeshen. Go ahead, sir, for five minutes.

Mr. Earl Dreeshen (Red Deer, CPC): Thank you, Mr. Chair, and thanks to all the witnesses for being here today.

I have a couple of different things. First of all—and I'll come back to it—I did want to speak about youth and some of the issues that are associated with all types of drug abuse. I was a high school math and physics teacher for 34 years, and I've seen a lot of kids who have gone through the system. I've seen situations where we would have these fantastic grade 8 students coming in, and by the time they hit grade 12.... You would see people coming around to prey on them, and sadly four or five years later you would see them in that same cycle, so I think it's so important we find ways of breaking that.

Of course, this is simply one more added feature we have now as we have the prescription drugs. I'm sure parents would love to know exactly just what is happening in that regard because in a lot of cases the drugs are coming from the parents. I think this is one aspect of it.

I would like to go back to some of the testimony that was given earlier. Mr. Bhupsingh, you spoke about the 2011 national workshop that had taken place, this facilitation of a multi-sectoral discussion and different ways of analyzing misuse of pharmaceuticals.

In a lot of cases you also talked about seniors and issues from the kinds of drugs they are prescribed. I was curious as to whether or not they have gone to senior drop-in centres and that type of thing to make sure the message is getting through there as well.

Mr. Trevor Bhupsingh: I'll say a few words, and then I'll turn it to my colleague, Ms. Goguen.

Back in 2011 I think what we recognized—and some of my colleagues have spoken about this—is we have tried not to take just a supply side and a total law enforcement perspective on this. What we tried to do back in 2011 was really bring in other sectors. So we brought in pharmacists and doctors to really talk about what the issues were and develop what we think are novel ideas in terms of trying to attack this issue.

The complexity around it largely deals with the fact that we are starting from something that is a legal commodity, so it's quite different from the illicit marketplace. It requires us to change our thinking in terms of what we are doing.

Let me leave it there, and I'll let Ms. Goguen address a couple of the other points you inquired about.

Ms. Taunya Goguen: I know you mentioned seniors. In respect of the prescription drop-off days, we've noted a few examples in the booklet that we left. One, you had police at certain locations aligned with pharmacists in many cases, which gave the public an opportunity to speak to medical professionals and police and to drop off their unused or unwanted prescription drugs. But there are a number of other models out there. One other reference is a Medi Drop out of Cornwall. It was a post office box that was used to drop off prescription drugs. As we continued to look across Canada to find other examples, we heard of examples related to seniors' homes where nurses would go in and take back the unused medication.

There's a whole sector out there who are unaware that it poses a risk to seniors to be holding on to these types of medications. It can even be a risk to their own safety as some people might try to take advantage of them for their prescription drugs. Many of those other models are occurring in the country.

● (1635)

Mr. Earl Dreeshen: Thank you very much.

Inspector Cormier, you mentioned that Corporal Chicoine could probably speak to some of the specifics. When you apprehend someone with a whole pile of different little pills in a bag, what is the process you have to go through to prove what you're actually dealing with, that the person didn't just lose the cap from their own prescription drugs?

Insp Jean Cormier: I will turn it over to Corporal Chicoine.

Corporal Luc Chicoine (National Drug Coordinator, Federal Coordination Centre, Federal and International Support Services, Royal Canadian Mounted Police): Thank you.

The process on the street depends a lot on the officer's situation. Obviously, it's difficult, with your scenario, to give you a precise answer. A bag with miscellaneous pills would usually be seized or some phone calls would be made to doctors or pharmacists to confirm the person's identity as well as details of the prescription such as dosage and quantities. That would usually be the rule on the street.

Mr. Earl Dreeshen: Commissioner Head, when you're in the penitentiaries, if you find that an inmate has been hoarding medication that he or she should have been taking on a one-a-day basis, how do you address that issue?

Mr. Don Head: There are a couple of things we do. If the individual had been on a self-administering regime, we would do an assessment of whether he or she could be trusted with certain quantities of medication. If we find a prisoner has been hoarding medication, we would probably put that person back on what's called a direct observation approach. This means that the prisoner would have to take the medication in front of a staff member, more than likely one of our nurses, and then go through a routine to demonstrate that the medication had been swallowed.

We also have the ability under the legislation to do drug testing through urinalysis, and we've increased the number of urinalyses by over 20% since last year. We will use that on a random basis. Also, if we suspect individuals, under certain elements within our legislation, we can have them tested as well.

The Chair: Thank you, Mr. Dreeshen.

Next up is Ms. Morin. Go ahead, please.

[*Translation*]

Ms. Isabelle Morin (Notre-Dame-de-Grâce—Lachine, NDP): Thank you, Mr. Chair.

My first question will be for Mr. Cormier.

I am also interested in young people. You say that the non-medicinal use of prescription drugs ranks third among the most frequent forms of drug abuse by Ontario students.

How do they obtain those drugs? Do you have any statistics on that?

Insp Jean Cormier: We do not really have any statistics on how they obtain the drugs. They use different methods which have already been mentioned. They steal it from their parents' or grandparents' medicine cabinets. In some cases, the drugs are distributed by dealers, which leads us to conduct investigations.

Ms. Isabelle Morin: The Criminal Code has provisions concerning illegal drug traffickers, but what happens in the case of someone who is distributing legal medication?

Insp Jean Cormier: The distributors of illegal drugs are not our responsibility, but that of the Canadian courts.

The dealers you refer to would certainly be subject to the same charges as those that were already mentioned, that is to say drug trafficking, or possession with intent to distribute. The sentence would depend on a certain number of factors, for instance whether the accused had a criminal record, and his age. It would be up to the courts to decide.

Ms. Isabelle Morin: I see.

Are there any provisions regarding parents who give their offspring access to medication from their medicine cabinet? You talked about students. So we are talking about youngsters in primary and secondary school. If the parents give them access to this medication, is that not negligence?

Insp Jean Cormier: There are no criminal provisions for such cases.

Ms. Isabelle Morin: I see.

The National Advisory Council on Prescription Drug Misuse has stated that:

> There has also been a surge of criminal activity for diverting prescription drugs from legal, regulated supply routes to illegal markets [...]

You talked a lot about awareness raising in the last little while. You said that increasingly, we must step up prevention.

I would like to know what diversion techniques currently allow people to acquire prescription drugs by accessing legal supply routes.

● (1640)

Insp Jean Cormier: It is difficult to answer that question. Drugs are diverted using different methods. It is what we call “diversion” in English. Legal drugs become illegal.

According to the process that is in place, when we learn that this is going on, basically, we carry out an investigation. That said, most of our programs are based on education and prevention.

Ms. Isabelle Morin: Can you talk to us about how this works between the federal and provincial governments? How do they make prevention work and make sure that this really reaches young people? Before I became an MP, I was a teacher. I never heard about these prevention tools for young people in Quebec. As you pointed out, the danger is that people think because a drug is on the market, sold in drugstores, that it presents no danger.

I would like you to talk to us about what is being done between the federal and provincial governments; how do you work together, and what partnerships have you formed to warn young people about the dangers involved?

Cpl Luc Chicoine: With regard to prevention, I have been a member of several groups whose purpose was to inform and help other first responders, that is to say police officers, firemen and paramedics, so as to increase their awareness regarding certain substances. The misuse of prescription drugs is a relatively recent phenomenon. It has become a much bigger issue over the past two or three years. This danger has now become much more prevalent. This led us to take action. I say “we”, but I am referring to police officers in general, from one end of the country to the other. This includes the RCMP, the Sûreté du Québec, as well as Ontario police forces.

The investigator's courses and those on prevention are all given at the Canadian Police College and the Ontario Police College. I am an instructor at both these colleges, and prescription drugs are one of the important topics I discuss.

At higher levels, it is up to the department to undertake prevention activities in schools. I can tell you that the RCMP does this in schools and with the general public. We try to improve people's knowledge of this issue.

Ms. Isabelle Morin: Fine.

Currently, if there were—

[*English*]

The Chair: You're over your time. Thank you.

[*Translation*]

Ms. Isabelle Morin: Thank you.

[*English*]

The Chair: Next up is Ms. Adams.

Ms. Eve Adams: Thanks very much.

Again, congratulations to our new chair.

Thank you very much for coming today and for your continued incredible service to our nation.

My colleague, MP Wilks, touched on a specific question: what drugs are actually being abused the most? There wasn't a concrete response to that. Do you have an appreciation, perhaps, of which prescription drugs children and youth seem to be abusing the most?

Mr. Paul Saint-Denis: I know that one of the drugs that has risen to the top as being extremely popular—and I can't tell you if it's specifically with very young children, teenagers, or young adults—is OxyContin. In the last several years, that has arisen as a drug of serious concern.

As of a couple of weeks ago, the Canadian Association of Chiefs of Police met and discussed these drugs as an issue. One of the drugs mentioned as a sort of an up-and-coming drug of concern was fentanyl. Fentanyl is an opioid that is extremely powerful. The chiefs expressed some serious concern about this particular drug, although it's not nearly as prevalent as OxyContin.

Ms. Eve Adams: As you can imagine it's a very serious issue for parents. What types of symptoms should they be on the lookout for? If your child happened to be abusing these types of prescription drugs, and these two are the most prevalent, what would be some of the warning signs you could look out for?

● (1645)

Insp Jean Cormier: If I may, I'm going to ask Corporal Chicoine to answer.

Cpl Luc Chicoine: To answer your first question a little more, it is difficult for us in law enforcement, or anybody sitting at this table here, to determine exactly which drug is the most abused because the drug that we know is the one we see, but the one being abused is the one we don't see. It's the one in all our medicine cabinets. It's that drug that is being removed, one or two tablets at a time, by the teenager or the youth or even the young adults, that is being abused. That is the one we don't see.

Ms. Eve Adams: That's very true. What I'm trying to get at here is a better understanding of the scope of the problem, and who is maintaining metrics on this. I think all around this table we understand this is a serious issue, but as we look to move ahead and deal with this issue, trying to have a firmer grasp on just how widespread this is, knowing which specific types of drugs are being abused would be helpful. Providing some concrete, practical information and advice to parents going forward would be helpful. Perhaps there is something you could share from your experience. But if the answer is we just don't know, perhaps you could direct me to where we might be able to find this type of information.

Cpl Luc Chicoine: Yes. As I was saying, the drug of abuse is going to be the one that we have in our cabinets so it could go from oxy that we have discussed, which has been seized in larger amounts, to fentanyl, which we've been seeing a lot, but there are others...bio-diazepam. A million other drugs are going to be abused, that are known through the Internet, that are known in a mixture of two tablets. One tablet of each kind can give a certain effect on the body. Obviously, the effect on the body is going to be different on each person as well, so it is very difficult to pinpoint exactly what the symptomatology is going to be without knowing which drug is being used.

Mr. Don Head: Perhaps I could add to what Corporal Chicoine is saying. Given that we have a captive audience and we're able to monitor it a little more closely, one of the things we see is that if you shut down one source, people who have an untreated substance abuse problem will look for some other form of drug, alcohol, intoxicant, inhalant to deal with their problem. I think part of what the corporal is saying is that although you may focus on one, and it may be the one that is prevalent today, it may not be tomorrow because you cut off that source, and people are going to find the next available drug.

Ms. Jennifer Goldstone: I can add to this. I believe last week our Health Canada colleagues talked about our concerns around abuse of pain relievers, sedatives, and stimulants, and how they do some tracking through the CADUMS, the Canadian Alcohol and Other Drug Use Monitoring Survey.

The Chair: That was perfect timing.

Next up is Ms. Sims. Go ahead.

Ms. Jinny Jogindera Sims (Newton—North Delta, NDP): First, let me say how delightful it is to be coming to a committee meeting on a Monday afternoon, especially the health committee.

I have a number of questions, and one of them follows up on one my colleague asked about the RCMP's collection and publishing of an annual report that used to occur, called the drug situation reports. The last report was published in 2009, as you said. As we all know, data is very important when we're tracking how we're doing in the system, because you can't just go by gut and people's different impressions. Yet this data—that used to be collected by the RCMP, that would have led to informed policy, informed decision-making around the kind of prevention we want to have, but would also give us a realistic view of what was happening out there in this area—doesn't happen anymore. I want to know why. Was it the RCMP who said we don't want to do this anymore, we don't need it as a tool? I'm looking at why such a valuable service was stopped.

Insp Jean Cormier: I'm not sure. Maybe one of my colleagues can answer why the report is not being produced anymore because some of the statistics would still be available. It's the publishing of the report, I believe, that is...when it comes to the statistics part of the report.

Ms. Jinny Jogindera Sims: Is there anybody who can answer why that report would not be published, so that people like us can actually take a look at it when we're making decisions?

● (1650)

Insp Jean Cormier: If nobody else can answer it's certainly something I can check into and get back to the committee.

Ms. Jinny Jogindera Sims: I would really appreciate that.

As a teacher and a long-term counsellor in both elementary and high school, one of the things I realize is that the drug situation is a serious situation. I don't think there is any disagreement on either side, or all three sides, or whichever way we want to look at it. But I think we also know that there are no simple solutions. We need a multi-pronged approach.

I want to pick up on a question that was asked by my colleague across the way, about prevention programs available for young people. I was very impressed with the answers you gave around all the training and everything that happens for the service provider end. But I also know that we could take up all our resources and not have anything left to spend on anything else unless we look at the causes and start addressing some of those and start with...education is the best antidote or the best medicine in this case.

Being a teacher from B.C., I've seen a lot of those resources disappear over the last number of years. When I left the education system—and that was a few years ago—by that time a lot of the prevention programs had already gone, not because people didn't want to do them, but because of funding. I have a lot of concern around that. I know you're here for the enforcement end, but I think it would be very naive to look at only the enforcement end without the context of what we're doing to address the whole area.

I have another comment I really want to make, and then I have a question. I come from the city of Surrey. I'm a member of Parliament for Newton—North Delta. Newton is the Surrey part. Today it almost devastated me when I read the news that we've had our 22nd murder of the year. When I read the report in the paper the comment was that the majority of the homicides, murders, have been drug or gang related. So I have a huge interest in this because I live in a community that simply rocks and is devastated every time another murder takes place, and we've broken a record this year. Most cities want to win records, but this is not the kind of record you want to have.

I suppose my question leading from that—and I have met with the police in my area—

The Chair: Ms. Sims, could you ask a quick question because you're using up your time.

Ms. Jinny Jogindera Sims: Okay, I am so sorry.

What kind of coordination happens between you and other authorities to look at finding solutions or developing a strategy that is multi-pronged and isn't only dealing with it at this end? What do we do about the other end?

The Chair: A brief response, if you can, please.

Insp Jean Cormier: I can answer this. My colleague wants to add something to it.

Certainly, we do have a strategy. When it comes to enforcement, we have enforcement strategies in place that include multi partners. We believe that addressing the problem involves not only the RCMP but is more a whole-of-government of Canada approach, all partners who would have enforcement or prevention or whatever their role in it may be.

As well, I believe in targeting the problem to address it, not only the symptom but the root cause of it. That is where we get involved into deeper investigation of criminal organizations that may be involved in this type of trafficking.

The Chair: Thank you, Mr. Cormier. We appreciate that.

Next up is Mr. Lizon for five minutes.

Mr. Wladyslaw Lizon (Mississauga East—Cooksville, CPC): Congratulations, Mr. Chair. I came late, and I would like to take this opportunity to congratulate you on your position and to thank our witnesses for coming here this afternoon.

I have a very basic question that may allow us to understand the problem better.

On the enforcement side, you have this group of people who abuse prescription drugs, you have those who commit criminal offences—obtaining them and then distributing them—and of course, you take appropriate actions. But now we have a group of people who would fall under prescription drug abuse because they go to the doctor and they somehow get hooked on the drugs. Technically, they don't do anything illegal, because they obtain drugs by getting a prescription from the doctor, or maybe from a few doctors if they wish to, and then they take them. And sometimes, if they have children or have some young people visiting, maybe they can get hold of the medication as well.

Now, how do you address that issue? The way I see it, there's really no criminal activity here, but the problem is here. So how do you address this? Do you have any examples, especially the RCMP, working with law enforcement agencies in different countries? Are there ways to limit it? Are there ways of approaching the problem that other countries have, other law enforcement agencies, and the medical profession as well?

I know it's very general, but it's a part of the problem that's not necessarily a criminal activity.

● (1655)

Mr. Paul Saint-Denis: Thank you, Mr. Chair.

Part of the answer is that under the CDSA, the Controlled Drugs and Substances Act, the offence of seeking or obtaining an authorization.... It is a requirement for anyone who obtains a second prescription to declare to the physician any prescription obtained in the 30 days prior to the second attempt to obtain. So there is an obligation for patients or individuals seeking to get a prescription to inform the doctor that they have obtained a prescription in the 30 days prior. That may be part of a response to your question.

Beyond that, perhaps our colleagues from law enforcement may have some views.

Insp Jean Cormier: Not really. I'm not aware of any other program in other law enforcement that would address that. Obviously, the development of prescription drug dependency would come down to control to start with, as to the amount of what is prescribed.

Mr. Wladyslaw Lizon: But if we look at the ways of monitoring drug use, this is something we can address. We can create an integrated computer system at least across the province or across provinces. The new technology of electronic labels, which will be on the market very soon, not only records usage of purchased drugs but also records and transmits that data to the system.

The technology is there. How far are we from actually adopting it? Is there anything that's being done? Is there anything you're aware of as far as monitoring goes?

Mr. Trevor Bhupsingh: I don't think it's an issue of the technology. I think there are programs and I think there are other more complicating factors that make it difficult to adopt that. Privacy with regard to the sharing of information is one factor. There are jurisdictional issues in terms of who is responsible for what. I know that is not something we can't overcome. I guess as we move through this, we're going to need an integrated way of looking at it. You mentioned in your opening that the complexity of this is that we're trying to deal with a lot of different populations, and the solutions aren't the same.

If as a starting point we're looking at a technology-based solution to track what we're doing with prescription drugs, I think there are some provincial models out there that are working well. Again, whether or not we need a national system is up for debate, and there are limitations around information sharing and jurisdictional issues.

● (1700)

The Chair: Thank you very much, Mr. Lizon.

Next up is Mr. Hawn, for five minutes, please.

Hon. Laurie Hawn: Thank you very much, Mr. Chair.

For our Department of Justice folks, privacy legislation can sometimes, with the new laws particularly, be an impediment to sharing information and so on. Is it an impediment to sharing information, and are there any differences among provincial, federal, and territorial privacy laws that exacerbate that?

Mr. Paul Saint-Denis: There are differences between federal and provincial privacy laws.

My colleague from the department is a specialist in privacy law, if you would like him to address that question, Mr. Chairman.

Hon. Laurie Hawn: Sure.

Mr. Denis Kratchanov (Director and General Counsel, Information Law and Privacy Section, Department of Justice): Good afternoon.

Your question is very good. It deals with what was said previously, in that obviously if someone is prescribed drugs for medical purposes that prescription is personal information about them, and it's information that is regulated under privacy laws in place at the federal level and in the provinces. Some of them deal with the public sector; others deal with the private sector. Certainly in the health environment, information is being created and used by different actors. Some of them are private actors; some of them are state actors.

It does make for some difficulties in that the purpose of such legislation is not necessarily to prevent the sharing of that information but to regulate it for certain purposes. Even though the legislation across the country is to some extent similar and based on the same broad principles, it's not exactly the same everywhere, and each case tends to be treated on a case-by-case basis.

On the use of prescription drugs, there are many circumstances that are perhaps different from others. Obviously you have patients who are law-abiding, who are using the drugs as they were prescribed, and you have others who may not be doing that. In different circumstances the law will authorize the sharing of information, and in others, perhaps not. Obviously that can be remedied by passing more laws, if that is necessary.

Hon. Laurie Hawn: Or fewer laws.

I want to come back to that, but I do want to ask the RCMP a question.

We've talked a lot about kids taking drugs from the cabinet and so on. Where does organized crime fit in to all this? Can you outline the concerns with respect to organized crime in this whole area?

Insp Jean Cormier: Certainly it is a market that is of interest to organized crime. Organized crime is involved in it. We've investigated cases in which we have found organized crime to be involved.

I believe that available intelligence on that would indicate that there are probably in excess of 70 different organized crime groups involved with it as well. The total number of organized crime groups operating in Canada is well in excess of 70 as you may already know.

Hon. Laurie Hawn: In this area specifically, how do they do that from an organized crime perspective? Do they go out and just gather all these prescription drugs and then market them, or how do they do that?

Insp Jean Cormier: There are different ways. It's much like it has been described before. It can be from theft from pharmacies. Some of them do, I guess, traffic prescription drugs, but some of them can be counterfeit prescription drugs as well, so there are different ways for them to get involved in that market.

● (1705)

Hon. Laurie Hawn: On the counterfeit prescription drugs, are they involved with marketing those to pharmacies somehow? Are they putting them into the system?

Insp Jean Cormier: No. I'm talking about illicit trafficking.

Hon. Laurie Hawn: Okay.

It's back to Justice again on the privacy laws and so on. You're an expert in this area. Is there something that can be done to balance that, to take away some of those impediments to sharing information? You said more laws; I would suggest maybe fewer laws.

Mr. Denis Kratchanov: I guess the laws we have right now do provide for communication and sharing of personal information in many circumstances. I guess from the sorts of problems I've heard about here today, there is a wide spectrum of situations that happen, from the patients who may lose their drugs, from those who might sell their drugs, from drugs that may be sold illegally, and the sharing for different purposes really needs to be looked at on a case-by-case basis.

Perhaps if there are certain scenarios that are more problematic in those types of situations, certainly we can find a standard response, but it would be difficult to give a complete answer to all of the problems you are facing here that would have a very simple solution.

Hon. Laurie Hawn: Is that part of what you look at?

The Chair: Mr. Hawn, you are out of time. Thank you very much.

Our final member to ask questions this afternoon is Ms. Fry. Go ahead, please.

Hon. Hedy Fry: Thank you very much, Mr. Chair.

A lot of questions are about how prescription drugs get abused. I think the most important thing to know about this is there's a process here. The doctor prescribes a drug. Opiates and opioids are very useful to deal with pain: post-operative, cancer, chemotherapy, all of that kind of thing. They are probably the best known painkillers going, either opioids or opiates.

But if you wanted to look at how you stop the chain, physicians, who are self-policing in every province, have... That's why I asked earlier on about sharing best practices. I know when I practised medicine a lot of people came to me, cross border, to try to get prescription drugs for opiates. They came across the provinces. They told me their doctor in Alberta, or their doctor in Winnipeg, etc....and I never did. I always said, “Give me the doctor's name, and I will call your doctor and just check up.”

What happens in B.C. that captures this is the college picks up what is known as a triplicate prescription. Whenever you write an opiate or opioid prescription, you have to write a triplicate prescription, and the college is able to look at the prescribing practice of doctor X, and why doctor X gives so many opioids or opiates, etc. And if they can share that with other provinces, you can stop that from happening. That's why that national program or pan-Canadian program of sharing that information among colleges would be a very important thing to do, to stop that.

But I wanted to go to something about the obligation of the patient to say, “Oh, my gosh, look at...”, too. These are very addictive drugs. When you get hooked you need to take the drug all the time, and so this becomes the problem. The patient has to.

Kids get it out of their parents' locker. A lot of the spread of prescription drugs on the street is because you can get, what?, $45 a tablet for OxyContin. So kids take it and they make money. People get it and they make money. They practise it. It becomes not necessarily organized crime in terms of large organized crime—there is some of that—but organized in terms of small communities of people trying to make money off it.

I think the important thing is to deal also with the addiction component. I need to get somebody to answer this question, which has never been answered, given that the most used opiate—we are number one in the world, surpassing the U.S.—is OxyContin. The U.S. has stopped making generic OxyContin which is easily usable on the street, and they have asked that this happen in Canada. The minister last year allowed for six generic pharmaceutical companies to make OxyContin.

Now, the United States Attorney General is asking for this to stop. How, as the supply-side policing part of it, do you allow this kind of thing to happen? Don't you talk to Health Canada and say, “This is going to go out on the street, people. Why are you allowing this to happen when across North America now it's not happening except in Canada?” This is a really important question to ask. If we are going to work together to deal with the problem, there has to be some sort of way of coordinating action that makes sense, common sense.

Can anybody answer that question for me? How does that make sense?

Okay. Thank you. I got my answer.

● (1710)

The Chair: If anybody has a thought at home tonight, please jot it down and forward it to the clerk of the committee.

That doesn't go into your time, Ms. Fry. Continue if you have any more questions.

Hon. Hedy Fry: I would like to know how much work you do, as you work with Health Canada and other groups, looking at the issue of actual demand.

Knowing that addiction is a chronic disease, a medical disease where we look at medical intervention.... Most people who are addicted are not addicted because they lack willpower; they are addicted because—we now know about—the neurotransmitters in the brain, etc., so everyone agrees with the idea of replacement therapy.

My question is this: What are we doing to deal, very clearly, with the demand side? Are you working together with Health Canada and the provinces in a reasonable way to deal with the issue of addiction per se and the medical problem, and how we can treat it and at the same time prevent harm? I simply want to know if you are involved in this. I know the police departments are. But in the RCMP, I'd like to know if you are looking at this from that perspective.

Insp Jean Cormier: Is the RCMP is involved with the different departments...?

Hon. Hedy Fry: No, also with other police officers around the country. In Vancouver, I know they are very much looking at addiction as a disease and not necessarily as an enforcement thing only.

Insp Jean Cormier: Right. Definitely in the nature of police work we certainly look at the enforcement side of things. But as I said, we do subscribe to the fact that it is not only a law enforcement issue but also a whole community issue, and everybody has a role to play in it—

Hon. Hedy Fry: But a medical issue. I want to talk about the medical component of it here and, therefore, harm reduction being a core piece of public health policy. For any medical disease, harm reduction is a piece. I go back to why it is that harm reduction used to be part of the policies up until 2005. Why has that changed? Why has harm reduction been removed?

Insp Jean Cormier: I'm not sure I'm in a position to answer that question.

Hon. Hedy Fry: Okay. Thanks.

The Chair: Thank you, Ms. Fry. We're right on time.

That will conclude this portion of our committee meeting. I thank the witnesses here today. Your support staff did a great job.

We'll suspend for a moment. We're going to go in camera and continue on with our committee business.

Thank you.

[*Proceedings continue in camera*]

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